COMMONWEALTH OF VIRGINIA

Department of Medical Assistance Services

PROVIDER NPI ATTESTATION FORM

This is to certify that:

Legal Name: _____

Medicaid Provider Identification Number: _____

has been assigned an National Provider Identifier (NPI): _____

NPI Type (Please circle one): Individual (Type 1) or Organization (Type 2)

by the NATIONAL PLAN AND PROVIDER ENUMERATION SYSTEM (NPPES) as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and mandated by the Secretary of Health and Human Services.

I declare under penalty of perjury under the laws of the State of Virginia that the information in this document and any attachments are true, accurate, and complete to the best of my knowledge and belief.

I understand that Virginia Medicaid will rely on this information in entering into or continuing a Virginia Medicaid Participation Agreement and that this form will be incorporated into and become a part of my Virginia Medicaid Participation Agreement.

I understand that I am responsible for the presentation of true, accurate, and complete information on all invoices/claims submitted to First Health Services. I further understand that payment and satisfaction of these claims will be from federal and state funds and that false claims, statements, documents, or concealment of material facts may be prosecuted under applicable federal and state laws.

_____ _____

Provider Signature Date

_____

Print Name